
Rural Emergency Medicine Survival Guide

*Rural Emergency
Medicine Section*

Contributor Guidelines

Why We're Writing This Book	2
It's a Question of Style: Our Q&A Format	3
"Where do these questions come from?"	3
What You Should Submit	4
Template	5
Manuscript Development Process	8
Topic Assignment	8
Manuscript Phases	8
Writing Resources	8
Housekeeping Issues	8
REM Website Resources	9
Senior Editor Team	9

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Why We're Writing This Book

You've been asked to help us write *Rural Emergency Medicine Survival Guide*. We want it to be the first-ever “**best practices**” for **Rural Emergency Medicine** based on evidence, expert opinion, and relevant guidelines. It will cover some specific clinical presentations unique to rural areas, but the larger mission is to teach physicians **how to provide the best care possible in resource-limited environments – how what we do is different from what our colleagues in tertiary care centers do.**

By necessity, there will be some overlap of information found in major emergency medicine textbooks, but we'll focus on **critical decision-making in the context of a limited-resource practice**. Our goal is to help physicians **improve patient safety and disposition efficiency without sacrificing quality.**

This is very different from the “high-tech” approach detailed in most major textbooks. Rural emergency departments simply do not have access to high-tech interventions or resources like pulmonary artery catheters, bedside ultrasonography, chest pain observation units, special tests like D-dimer, BNP, lactic acid level ... and the list goes on. But with a book like this one, we can follow **recommendations of experts** and improve the quality of care we provide.

The “voice” of the book will be the same as the “voice” of Rural Emergency Medicine: **practical and pragmatic**, considering only the resources that are likely to be available to us in our rural practices, and, just as important, identifying when transfer to a higher level of care is necessary. Speaking in that voice will be about 60 other contributors, a senior editor team with more than 100 years of Rural Emergency Medicine practice experience, and you.

Here are the objectives of this book we'll be writing:

- **Meet unmet workforce and education needs.** Multiple workforce reports by ACEP and the Institute of Medicine over the past decade have detailed the need to increase the supply of emergency medicine specialists and provide emergency medicine-focused education to the non-emergency medicine-trained physicians who are providing the majority of care to patients in rural areas.
- **Inspire young emergency physicians to consider a career in Rural Emergency Medicine.** We hope this book will show the next generation of physicians that high-quality emergency medicine in a resource-limited setting is not only achievable but also very professionally rewarding.
- **Promote evidence-based tools, assessments, and decision-making** to the greatest extent possible. We want to guide physicians to the pathways others have developed and tested, whether under the most rigorous EBM approaches or through years of real-life experience. And we also want to identify areas where future research is needed.

It's a Question of Style: Our Q&A Format

To help you write your chapter for *Rural Emergency Medicine Survival Guide*, the senior editor team has come up with two organizing principles. One is a template, which is shown on page 5, and the other is a **Q&A format**.

Our goal is to answer the major critical questions that cover 80% to 90% of the “need-to-know” issues for each topic within the context of limited resources. We want this book to stay focused on **what's different about our approach to care**. For our voice to be unique, we must focus on detailing **critical history elements, physical findings, bedside maneuvers, and usable, relevant clinical decision rules**. The Q&A format will help you efficiently guide our readers through these critical questions.

“Where do these questions come from?”

- The senior editors – your assigned editor, in particular – will give you questions to answer in your chapter draft.
- Members of the ACEP Rural Emergency Medicine Section of Membership will also provide questions.
- And you should suggest questions, too, if you think there are other key decision points that need to be addressed.

The answers to your questions should be **evidence based** to the greatest extent possible. For example, in a discussion of suspected pulmonary embolism, review the relevant guidelines, clinical decision rules, and best practices most often cited in the literature (PERC rule and Wells criteria for PE evaluation). Your answers also should take into consideration relevant ACEP policy, especially noting where there are limitations due to resources or personnel. In the absence of evidence, describe expert consensus. And if your recommendations are based on your own experience or that of others, say so. If you have questions about whether a source of a recommendation is acceptable, talk with your editor.

Here are some **other principles to keep in mind** when you're researching and writing your answers:

- Be brief (“Brevity is the soul of wit,” said Shakespeare).
- Emphasize a risk stratification and critical action approach (consider “worst first,” the EMC DDX as opposed to the traditional “most likely” DX approach used in low-acuity settings).
- All facts, heuristics, and so on must be useful to decision-making, mindful of cognitive pitfalls, bias, and patient safety principles.
- If data are available, give the sensitivity, specificity, and negative predictive value of history elements, physical findings, and routinely available tests.
- Discuss in detail only those medications/tests/bedside procedures that would be readily available (if you're not sure, ask your editor).

- Highlight useful validated clinical decision rules, usable guidelines, and so on, and cite their sources.
- Emphasize where further clinical research is needed.
- Emphasize the importance of and tactics for effective communication.
- Emphasize when collaboration and coordination with attendings and consultants are expected.
- Differentiate between when it is safe to defer workup to an outpatient setting and when a suspected condition mandates transfer.
- Discuss safe disposition decision-making and patient education.

What You Should Submit

- Your **chapter draft** written according to the template and the Q&A format, in Word, double-spaced, in 11-pt. Times New Roman, with at least 1-inch margins. Use a header or footer that includes page numbers, your name, and your chapter name. Keep it to xx to xx pages. If you can't answer all the questions within this number of pages, talk with your editor. **Keep your format simple.** We don't need fancy tables or fonts. One space between sentences, please, and use tabs rather than multiple spaces.
- Lists, bullet points, tables, pictures, other **quick-reference tools** our readers will find helpful – the kinds of tools you would find useful.
- **Permissions** – if you want to use a table or figure from something that has already been published, you must get permission in writing from the copyright owner even if you find it on the Internet. We don't have a budget to pay permission fees, so be prepared to persuade publishers to do their part to help educate doctors and improve patient care. Most images on the Internet are not high-resolution enough for printing. If you find something you want to use, ask your editor.
- **References** – when you use information published in an article or a book chapter or some other source, you must reference it in the same way you would if you were writing a journal article: cite your source using superscript numbers in the text (sequentially as they appear) and then provide a list of those sources with their corresponding reference numbers at the end of your draft. A bibliography is an alphabetical list of the books and other resources you consulted, and it's not sufficient for this book; you must indicate which points came from which sources. We also must prevent plagiarism. Don't copy text from your sources. Read your source material, close it, then restate it in your own words. Be sure to use current editions of all textbooks and guidelines. Here are sample reference formats:
 - **Journal article:** Herndon JB, Chaney M, Carden D. Health literacy and emergency department outcomes: a systematic review. *Ann Emerg Med.* 2011;57(4):334-345.
 - **Book chapter:** Johnson GA, Prince LA. Aortic dissection and related aortic syndromes. In: Tintinalli JE, Stapczynski JS, Ma OJ, et al, eds. *Tintinalli's Emergency Medicine: A Comprehensive Study Guide.* 7th Ed. New York, NY: McGraw-Hill; 2011:450-453.

- **Web site:** Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines 2010. *MMWR Morb Mortal Wkly Rep.* 2010;59(12):1-110. Available at: <http://www.cdc.gov/std/treatment/2010/STD-Treatment-2010-RR5912.pdf>. Accessed January 19, 2011. With erratum for pages 50, 51, 57.

Template

- Chapter number
- Chapter title
- Your name, other contributors' names, titles, affiliations as you want them published
- Chapter overview
- Emergency medical condition DDX to be discussed (clinical chapters only)
- Q&A – The questions assigned by your editor, with your answers
- Summary of key points
- Bullet list of potential pitfalls (clinical chapters only)
- Bullet list of patient education points (clinical chapters only)
- Web resources
- References

Here's a sample chapter that shows the template elements (does not represent a complete chapter):

Chapter 18

Chest Pain

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Chapter Overview

The evaluation and safe disposition of patients who present to rural emergency departments with chest pain challenge even the most experienced physicians. Rural emergency physicians must depend primarily on a detailed history, focused physical examination, prompt ECG, and biomarkers to immediately risk stratify a patient's condition to ensure safe disposition. Nontraumatic chest pain in adults comprises approximately 5% of emergency department visits, and missed myocardial infarction (MI) is the greatest medical malpractice risk in terms of total cost in dollars. Prior to a structured risk stratification approach, it was estimated that 2% to 6% of all patients with MIs were inadvertently sent home.¹ Rural emergency physicians must discipline themselves to diligently work through the appropriate lines of questioning, focused examination, and testing that reasonably would be expected to screen for the most

common emergency medical conditions that can present with the chief complaint of chest pain (or its equivalent). Rural emergency physicians must have a clear understanding of when it is safe to discharge without consultation, when to consult, when to transfer, and how to explain the complex process of chest pain evaluation to patients and their families in a way that they can understand and participate in decision-making.

What findings indicate that a patient with chest pain might need transfer to a higher level of care?

- Persistent chest pain despite anti-anginal regimen
- Dynamic ECG changes (compared to old ECG)
- Need for pacemaker
- Suspected aortic dissection
- STEMI
- Signs of respiratory or circulatory failure (if no ICU care available)
- Pneumothorax with chest tube (if no surgical back up)

Because each rural facility has various capabilities and prior established relationships, disposition of chest pain patients with significant risk should be done in collaboration with the patient's PCP or the attending on-call.

Summary of key points

- Make it a priority to obtain an ECG and give to EP within 10 minutes of arrival.
- Immediate risk stratification working through your EMC differential diagnosis
- If chest pain (or equivalent) is suspicious for ACS, follow ACC/AHA algorithm.²
- All patients presenting with chest pain due to a possible EMC need IV access and need to be on a monitor.
- Consult on-call backup if chest pain suspected to be EMC (ACS and non-ACS).
- Charting should reflect that you worked through the EMC differential.
- "Very low risk" patients can be discharged without consultation.

Pitfalls in the assessment of chest pain

- Delay in obtaining an ECG.
- Failure to appropriately risk stratify the patient's presentation, thus sending home a high-risk patient.
- Failure to appreciate atypical presentations in elderly and diabetic patients.
- Allowing cognitive bias to interfere with reasonable assessment and disposition.
- Failure to recognize high-risk ECG findings such as false reassurance of a normal ECG.
- Failure to involve the patient and family members in collaborative decision-making.
- Failure to collaborate with backup on disposition, thus jeopardizing continuity of care.

- Failure to transfer in a timely manner.

Patient education points for chest pain

- Chest pain can have a serious cause like heart disease, often not diagnosed in the emergency department.
- Heart disease workup is a three-step process, and only the first step can be done in the emergency department.
- Must emphasize importance of followup and immediate return if symptoms recur.
- In all patients with suspected ACS who want to leave AMA, the emergency physician should assess for and document decision-making capacity, inform the patient/family of risks and benefits of the proposed plan, and give the patient an opportunity to ask questions and state his or her reasons for refusing care. Pain medication, a discharge plan, and an invitation to return if worse should also be given. The AMA process should be executed with a nonpunitive attitude.

Web Resources for Chest Pain

- If possible provide specific links to high quality discussion of topics covered
- American College of Emergency Physicians www.ACEP.org
- American Heart Association www.AmericanHeart.org
- eMedicine: Emergency Medicine – Angina Pectoris in EM www.eMedicine.com

References

1. Schull MJ, Vermeulen MJ, Stukel TA, et.al. The risk of missed diagnosis of acute myocardial infarction associated with emergency department volume. *Ann Emerg Med.* 2006;48(6):647- 655). Available at: <http://www.annemergmed.com/article/S0196-0644%2806%2900423-9/abstract?source=aemf>. Accessed: [date]
2. Anderson JL, Adams CD, Antman EM, et al. ACC/AHA 2007 Guidelines for the management of patients with unstable angina/non-ST-segment elevation myocardial infarction. *Circulation.* 2007;116:803-877.

Manuscript Development Process

Topic Assignment

- Send your CV to Bonnie Wreshner, bwreschner@gmail.com, with a brief bio and title and preferred contact information, along with any preferred topics to write about. Visit the Section Web site to review the table of contents.
- Bonnie will send you your assignment and contact information for your assigned editor.
- Communicate with your editor to let him or her know that you have accepted the assignment and to find out his or her communication preferences.
- Your editor will send you the questions for your Q&A.
- If you come up with additional questions, discuss them with your editor.
- Get in touch with our EBM expert Ken Milne, monycon@hurontel.on.ca, for suggestions on relevant emergency medicine-based clinical decision rules or tools pertinent to your topic that you should direct readers to and reference.

Manuscript Phases

- Draft Phase - You will be given 1 month from assignment to produce a draft of your chapter.
- Senior Editing Phase – Forward your first draft to your assigned editor, with a copy to Bonnie. Work collaboratively with your editor to refine the chapter (suggest using [MS Track Changes](#) functionality in Word) or [Google Docs](#) to exercise strict version control. Once consensus is reached that your manuscript is ready for final review, send it to the Chief Editor, with a copy to Bonnie.
- Chief Editor Phase – The Chief Editor will review and edit your draft, working collaboratively with your assigned editor. You might be asked to provide more information or revisions, so please be prepared to do that according to schedule.) After your chapter has been approved by the editor-in-chief, it will be reviewed and edited by Randy Knight and then finalized for the publisher.

Writing Resources

- [The Science of Scientific Writing](#)
- [Tips for Writing a Scientific Paper](#)
- [Resources in ACEP Bookstore](#)

Housekeeping Issues

- ACEP copyright assignment agreement (**All members of team must sign CAA**)
<http://www.acep.org/Content.aspx>
- ACEP Policy (**Integrate all relevant ACEP policies into your work**)
 - ACEP Clinical Policies (<http://www.acep.org/clinicalpolicies/>)
 - ACEP Policy Statements (<http://www.acep.org/policystatements/>)
- E-mail Convention (for ease of filing and retrieval of the multitude of e-mails)
Use as **Subject line: REM: “Topic of e-mail”** for all REM Guide related e-mails.

REM Web Site Resources

- [Rural EM Section Home Page](#)
- [Survival Guide Home Page](#)
- [Table of Contents](#)

Senior Editor Team

- Chief Editor – Harry “Tripp” Wingate III, MD, FACEP
- Project Coordinator – Bonnie Wreshner, MD
- ACEP Liaison – Buck Beighley
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 - Bob Solomon, MD, FACEP (ACEP Board Liaison to Section)
 - Jonna Graves, MD (Chair Elect 2011 REM Section)
 - Randy Knight, MD, FACEP (Newsletter Editor for Section)
 - Ed Leap, MD, FACEP (Renowned writer, speaker in EM)
 - Todd Grant, MD (Editor for CALS, EHR developer)
 - Ken Milne, MD (BEEM Editor)

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